STATEMEMT OF
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BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

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Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to be here today to discuss the many positive steps the Department of Veterans Affairs (VA) utilizes to monitor the healthcare of our veterans and returning warriors. In my role as Deputy Under Secretary for Health for Operations and Management, I am responsible for the day to day activities at all of our facilities across the country. I would like to focus my attention on how the Veterans Health Administration (VHA) addresses quality improvement activities on a system-wide basis. I am accompanied by Dr. John Pierce, Medical Inspector, Dr. James Bagian, the Chief Patient Safety Officer, and Dr. Barbara Fleming, Chief Quality and Performance Officer.

OVERVIEW

In the late 80's, VA health care programs came under a great deal of scrutiny because of the perception that quality was not comparable to that found in the private sector. Since that time, numerous programs have been implemented by VA to address and ensure that the quality of health care provided to our veterans is world class. The results of these efforts and achievements have brought national recognition to VA as consistently being recognized as one of the premier health care providers within the United States. For example, on January 20, 2006, the Washington Post published an article entitled "VA Care is Rated Superior to That in Private Hospitals," and the January/February 2005 issue of the Washington Monthly published an articled entitled "The Best Care Anywhere." And the August 27, 2006 issue of Time magazine had a feature article entitled, "How Veterans Hospitals Became the Best Health Care". While

VA has transformed itself, we continue to strive to improve the quality of health care provided to our nation's veterans through shared learning, research, and vigorous and stringent quality management and patient safety programs.

The results of this work can be attributed to the leadership and contributions made by the offices represented by those accompanying me today—the Office of the Medical Inspector, the National Center for Patient Safety, and the Office of Performance and Quality—as well as the efforts of our VA workforce who are directly involved in patient care.

VHA ensures the consistent quality of care that is delivered in its Veterans Integrated Service Networks through –

- Patient safety activities;
- Systems that listen, teach and detect problems early;
- Ongoing measurement of clinical processes;
- Establishment and control of quality standards for both clinical protocols (Peer Review, Evidence-Based Guidelines, Utilization Management) and for the providers of care (National Credentialing and Privileging);
- Personal and anonymous patient surveys after the care has been provided;
- Oversight by external organizations such as the Joint Commission; and
- Oversight by internal organizations such as Systematic Ongoing Assessment and Review Strategy (SOARS), Office of Medical Inspector (OMI), Office of Inspector General (OIG), Government Accountability Office (GAO), Veterans Service Organizations (VSO).

PATIENT SAFETY

The VA National Center for Patient Safety (NCPS) is guided by a mission to prevent harm to patients. The focus is to prevent inadvertent or accidental harm that may occur as a result of incidents such as patient falls, medication errors, malfunction or misuse of medical devices, and hospital-acquired infections. The NCPS works with Patient Safety Managers in all VA medical centers and Patient Safety Officers in the network offices to facilitate the implementation of an integrated patient safety improvement program throughout VHA. The primary methodology used in VHA to understand and prevent adverse events is Root Cause Analysis (RCA). The RCA teams focus on determining what happened, why it happened, and what systems changes should be made to prevent similar incidents from recurring. Information from RCAs is used to inform other VAMCs of potential problems, potential solutions, and in the development of VHA-wide policies and practices to prevent adverse events from occurring in VHA facilities.

The NCPS also issues Patient Safety Alerts (Alerts) and Advisories on specific issues relating to medical devices and products, and other potential sources of harm to patients. Several Alerts have brought problems coupled with recommended solutions to the attention of other government agencies such as the Food and Drug Administration (FDA), and organizations such as the Joint Commission. Topics of recent Alerts of special interest included one that led to the withdrawal of Benzocaine spray from our facilities due to its high potential for accidental misuse and dangerous overdoses, and another one that described the correct way to clean and disinfect a special ultrasound device used for prostate biopsies. Both Alerts were of special interest to the FDA and resulted in FDA disseminating the potential vulnerabilities brought to light by VA to hospitals in the private sector.

Another method to improve quality and patient safety is to reduce ineffective variation in practices. This is where VHA Directives (Directives) are issued to address patient safety topics. Based on information from RCAs, emerging standard practices, and

other sources, VA has developed and implemented several important Directives to improve patient safety such as: *Ensuring Correct Surgery and Invasive Procedures; Prevention of Retained Surgical Items; Out-of-Operating Room Airway Management; Recall of Defective Medical Devices and Medical Products; Planning for Fire Response; Reducing the Fire Hazard of Smoking when Oxygen Treatment is Expected; and Required Hand Hygiene Practices (based on the CDC's Guideline on this topic).* These topics vary widely but are all related to preventing harm to patients as they receive care at a VA facility. By issuing these Directives, VA has acquired the ability, as the largest integrated healthcare system, to effect change that impacts millions of patients.

PERFORMANCE MEASUREMENT

VA's performance measurement system is a key part of the transformation of care that started in the mid-1990s. The system has over 100 performance measures in the areas of access, satisfaction, cost, and quality. Data on these measures are collected monthly and all performance is shared and distributed on a quarterly basis to the field facilities with information broken out into aggregate totals for facilities, networks and VHA overall. The aggregated quarterly data is also used to produce detailed annual reports shared with senior leadership and the field.

Special reports are also produced that focus on particular measures of concern or special populations. For example, reports have been provided on minority health, women's health, the health of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans, and characteristics of facilities and networks leading to high performance with Best Practices shared across the system via video conferences which are web-based and enhanced and national face to face meetings.

These data analyses lead directly to quality improvement efforts. When quality concerns are identified, working task groups have been convened to further explore these issues using collected data and working directly with the VA facilities to find and share solutions to the quality problems. VA consistently benchmarks its performance

data, both internally and externally. Ongoing reports are prepared that compare VHA to other Federal and private sector health care organizations.

The successful use of the performance measurement system for driving quality is based upon widespread dissemination of information and feedback to individuals at all levels of the health care system. Also, it is important to link measures not only in performance evaluations but also incentives in a variety of local and national means, for example, through awards to facilities, and networks. Linkage of measures to performance contracts result in personal accountability. In addition, for each quarter, I conduct individual performance reviews with each Network Director to personally review performance measure results for their VISN and to discuss plans for improving performance in areas that are needed. The Network Directors are held accountable for performance improvement through performance measurements.

CREDENTIALING AND PEER REVIEW

VA also has a very sophisticated electronic credentialing program that is used system wide. We believe that careful credentialing is a cornerstone of assuring quality. The quality of privileging, which defines the practice scope of a provider, is also essential to maintaining a good clinical staff.

Peer review is another mechanism in place to assure that the highest quality of care is delivered. Peer review is intended to contribute to quality improvement efforts of the individual provider, in a non-punitive way.

UTILIZATION MANAGEMENT

Utilization Management (UM) allows the VA to determine that the right care is provided to the right patient at the right place for the right amount of time. A national Utilization Management Committee has put standards for UM in place, adopted nationally standardized criteria, conducted extensive training, and is beginning the implementation of a national data base to assure that there is facility, national, and network learning and quality improvement around the data collected.

Patient complaints are assessed by a series of questions on the inpatient and outpatient surveys asking whether the veteran had a complaint about VHA care, and whether the veteran was satisfied with the resolution of that complaint. Patient advocates and the national VHA Patient Advocacy Office monitor these results closely to ensure that veterans' and their families' voices are being heard.

SYSTEMATIC ONGOING ASSESSMENT AND REVIEW STRATEGY

The VA utilizes a learning system that exports and disseminates information to all segments of the VA health care system so that providers can learn how to deliver care that is not only safe, efficient, cost- effective, but clinically measurable and evidence-based. For example, the Systematic Ongoing Assessment and Review Strategy (SOARS) is an internal review initiative that was initially implemented within the VA as an internal voluntary program that facilities could use as a systematic method for on-going self-improvement and to support the culture of continuous readiness. Now, based on the success of this program, all VA facilities participate in a SOARS site visit every three years. As the SOARS team members interview staff, they frequently become aware of an excellent practice implemented at the surveyed site that could improve patient care quality or efficiency or reduce costs that could easily be shared with other VA facilities. The information regarding these "Strong Practices" is kept on the SOARS VA intranet web site that is easily accessed by all VA staff.

OFFICE OF THE MEDICAL INSPECTOR

Another internal review mechanism involves the reviews done by the Office of the Medical Inspector who evaluates quality of care concerns raised by veterans and other stakeholders and makes recommendations to enhance and improve the quality of care provided by VHA. These recommendations are directed at the facility involved in the site visit. When common issues are identified, the recommendations may result in a Directive or guidance to the entire VHA system.

EXTERNAL OVERSIGHT

As a public system, the VA undergoes intense scrutiny from a variety of accreditation agencies, both internal and external reviewers. All VA medical facilities are accredited by the Joint Commission on Accreditation for Healthcare or organizations on a triennial cycle.

The Office of the Inspector General (OIG) for the VA, and the Government Accountability Office are frequent inspectors of care provided at individual VA facilities and often address issues that cut across specific VAMCs. For each review, VHA drafts a response and action plan to respond to findings. We welcome the opportunity for external regulators to help us identify areas where improvement is needed and strives hard to make those improvements.

CONCLUSION

As a system, VA is continuously looking for opportunities to learn and improve. The components described above provide a solid foundation for identification of problem areas and challenges for the system of care that can be transported to improve our entire healthcare delivery system for individuals.

One of the advantages of being a large integrated health care organization is that VHA has the ability to learn and share examples of best practices from our clinicians and administrators across our entire system. I personally speak with the Veterans Integrated Service Network (VISN) Directors as well as Facility leadership on a weekly basis; best practices are identified and shared via these teleconferences. In addition, conference calls are held by my colleagues with patient safety and quality management staff. There are many examples of how VA learns from specific clinical incidents.

I appreciate the opportunity to talk with you today. The events at Salisbury have spurred us to go even farther in our monitoring process than I have described here. I have asked that the Network Chief Medical Officers and Quality Managers heighten their personal ownership of issues affecting their facilities and ensure that best practices are shared system-wide. Mr. Chairman, this concludes my statement. At this time I would be pleased to answer any questions that you may have.